

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002408	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2014
NAME OF PROVIDER OR SUPPLIER DUPONT HOSPITAL LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 E DUPONT RD FORT WAYNE, IN 46825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Date of survey: 8/13/2014.</p> <p>Facility number: 002408</p> <p>Complaint number: IN 00145793</p> <p>Unsubstantiated: allegation did not occur</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>Dupont Hospital, LLC is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8, Physical plant, maintenance and environmental services.</p> <p>QA: cloughlin 08/29/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE